AFC LICENSING - HEALTH CARE APPRAISAL

Michigan Department of Consumer and Industry Services

Licensee Name	Resident Name		Case Number
AFC Facility Name	Facility License Number	Worker Name/ Load #	Worker Phone Number

Release of General Medical Information: By signing this form, I understand that I am authorizing the release of medical information concerning me to the licensee and licensee's staff, the responsible agency, and the Michigan Department of Consumer and Industry Services, Bureau of Regulatory Services for the purpose of providing appropriate care to me and determining compliance with licensing rules.

Signature of Resident/Legal Guardian	Title	Date

Release of HIV/AIDS/ARC Information: By signing this form, I understand that I am authorizing the release of medical information concerning me , including information regarding Acquired Immunodeficiency Syndrome (AIDS), Aids Related Complex (ARC), or Human Immunodeficiency Virus (HIV), if applicable to the licensee and licensee's staff, the responsible agency, and the Michigan Department of Consumer and Industry Services, Bureau of Regulatory Services, for the purpose of providing appropriate care to me and determining compliance with licensing rules.

Signature of Resident/Legal Guardian	Title	Date

1.Height	2.Weight	3.Ideal Weight Range	4.Blood Pressure	5.Age	6.Sex ☐ MALE ☐ FEMALE

7 Diagnoses

8. Current Medications and Instructions

9. Allergies

10. General Appearance

11. Mental/Physical Status and Limitations

12. Mobility/Ambulating Status

☐ Fully Ambulatory ☐ Uses Walker

☐ Uses Cane ☐ Uses Wheelchair

13. Susceptibility to Hyper/Hypothermia and Related Limitations

14. Special Dietary Instructions and Recommended Caloric Intake

15. Physical Exams:

TYPE	NORM	ABN	** DEFERRED
1. Skin			
2. Ears			
3. Nose			
4. Throat			
5. Mouth			
6. Neck			
7. Breasts			
8. Chest			
9. Lungs			
10. Heart			
11. Abdomen			
12. Extremities Upper			
Lower			
13. Feet/Toes			
14. Lymph Nodes			
15. Genitalia			
16. Testes			
17. Spine			
18. Reflexes			
19. Neurological			
20. Rectal			
21. Sexually Transmitted Diseases ☐ YES ☐ NO			
22. Other:			

** Deferred , as used here, means examination considered but postponed.

Explanation of Abnormalities/Treatment Ordered

16. Other Health-Related Information or Concerns

Physician or Health Care Practitioner (Please Print)		Date		
Physician Address		City	State	Zip Code
Signature	Title	Date	Date of Exam	

AUTHORITY: P.A. 218 OF 1979
COMPLETION : Required
CONSEQUENCE: Violation of AFC Licensing Rules

The Department of Consumer and Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs.

BRS-3947w (Rev. 7-96) Previous edition Rev. 1-96 ONLY may be used.